



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

April 23, 2007

Kary Johnson, Administrator  
The Cottages of Mountain Home  
735 S 5<sup>th</sup> West  
Mountain Home, ID 83647

On January 5, 2007, a recertification survey was conducted at the Cottages of Mountain Home. On February 6, 2007 a Level 1 Informal Dispute Resolution (IDR) hearing was held with corporate representatives and the Department. As a result of the IDR proceedings, the survey report has been amended. Enclosed is the amended Statement of Deficiencies.

Also, enclosed is a form indicating the results of the IDR. This form is for your records only and need not be returned.

The Plan of Correction (POC) submitted by the facility prior to the IDR, addresses the Statement of Deficiencies as amended. The POC is acceptable; therefore, an updated POC is not required.

Thank you for your participation in the IDR process.

Sincerely,

A handwritten signature in black ink, appearing to read 'JS' or 'J. Simpson', written over a horizontal line.

JAMIE SIMPSON, MBA, QMRP  
Supervisor  
Residential Community Care Program

JS/sc

Enclosure

IDAHO DEPARTMENT OF HEALTH & WELFARE  
DIVISION OF MEDICAID  
BUREAU OF FACILITY STANDARDS

3380 Americana Terrace, Suite 290  
P.O. Box 83720  
Boise, ID 83720-0036

**Informal Dispute Resolution Results**

Facility Name: The Cottages of Mountain Home

IDR Date: February 6, 2007

Survey Exit Date: January 05, 2007

Survey Type (check all that apply):  
☐ Initial ☒ Full  
☐ Reportable Incident ☐ Fire/Life Safety & Sanitation  
☐ Follow-up ☐ Monitoring

Participants: Mark and Gerold Maxfield, Owners  
Jamie Simpson, Residential Community Care Supervisor, Facility Standards  
Debby Ransom, Bureau Chief Facility Standards

**RESULTS**

DISPUTED TAG(S)	Supported in Full	Amended	Deleted
IDAPA 16.03.22.520		X	

Notes:

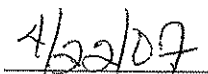
IDAPA 16.03.22.520 was deleted as Resident#4 was not assessed to be at risk for leaving the facility. When the resident's behavior was such that her confusion was increased there was sufficient staff to redirect the resident.

The finding regarding a secure environment for Resident #1 was deleted as she was not assessed to be at risk for leaving the facility. The finding regarding physical restraints is upheld. The assessment for use of the side rails is inadequate and does not support the need for positioning. The NSA does not document the need for side rails and the only documentation available (accident and incident report) indicates they are being used to keep her in bed.

Signature of Bureau Chief:



Date:





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E-mail: [fsb@idhw.state.id.us](mailto:fsb@idhw.state.id.us)

January 12, 2007

**CERTIFIED MAIL #: 7003 0500 0003 1967 0483**

Karen Kleffner, Administrator  
The Cottages of Mountain Home  
735 S 5th West  
Mountain Home, ID 83647

Dear Ms.. Kleffner:

Based on the state licensure survey conducted by our staff at The Cottages of Mountain Home on **January 5, 2007**, we have determined that the facility failed to protect residents from inadequate care. Based on observation, interview, and record review it was determined the facility retained residents who had cognitive impairment and the facility did not provide an interior environment and exterior yard which was secure for 2 of 4 sampled residents identified as at risk for wandering outside and off of the facility property.

This core issue deficiency substantially limits the capacity of Cottages Of Mountain Home, The, Cottages Investors Ii, Llc to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **February 24, 2007**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ♦ What date will the corrective action(s) be completed by?

Karen Kleffner, Administrator  
January 12, 2007  
Page 2 of 2

Return the **signed and dated** Plan of Correction to us by **January 24, 2007**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

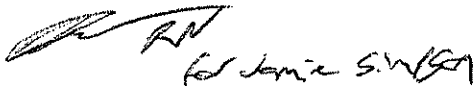
In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**January 24, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **January 24, 2007**, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **February 2, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Cottages Of Mountain Home, The, Cottages Investors II, LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read "for Jamie Simpson", is written over a printed name.

JAMIE SIMPSON, MBA, QMRP  
Supervisor  
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards  
Marilyn Kelseth, RN, Program Manager, Regional Medicaid Services, Region IV - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R727</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/05/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGES OF MOUNTAIN HOME, THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>735 S 5TH WEST MOUNTAIN HOME, ID 83647</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p><b>Initial Comments</b></p> <p>The following deficiency was cited during the standard survey conducted at your residential care/assisted living facility. This survey incorporates changes resulting from the Informal Dispute Resolution Process.</p> <p>The surveyors conducting your survey were:</p> <p>Patrick Hendrickson, RN Team Coordinator Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Survey Definitions: MAR = Medication Assistance Record mg = milligrams mcg = micrograms NSA = Negotiated Service Agreement Q = every UAI = Uniform Assessment Instrument</p>	R 000			
R 008	<p><b>16.03.22.520 Protect Residents from Inadequate Care.</b></p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the facility retained resident who required physical restraints (bed rails). This practice affected 1 of 4 sampled residents (#1). The findings include:</p>	R 008			

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

UTR211

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R727</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/05/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGES OF MOUNTAIN HOME, THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>735 S 5TH WEST MOUNTAIN HOME, ID 83647</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 008	<p>Continued From page 1</p> <p>Review of the facility's "Admission And Discharge Policy" on 1/3/06 documented that " no resident would be admitted or retained for whom this facility does not have the capability or services to provide appropriate care."</p> <p>On 1/2/06 at 2:45 p.m., the resident's bed was observed to have 1/2 bed rails at the top of each side of the bed.</p> <p>Review of Resident #1's record on 1/3/07 revealed the resident was admitted on 11/2/05, with a diagnosis of dementia.</p> <p>Review of the facility's "Incident / Accident Reports" revealed the resident fell out of bed on 3/6/06, 6/19/06, and 10/19/06.</p> <p>The resident's record contained "Daily log" notes that revealed the resident had also fallen out of bed on 12/10/06.</p> <p>Further review of the "Incident / Accident Report," dated 6/19/06 documented under the section "What If Anything Can Be Done In The Future To Prevent Similar Incidents," staff wrote "maybe get longer bed rails so she can't fall out."</p> <p>On 1/3/07 at 9:30 a.m. a caregiver stated the resident had episodes when the resident is "not all there" and has fallen out of bed; so the bed rails are there "to keep her from falling out."</p> <p>The facility retained a resident (#1) who required physical restraints (bed rails). This failure resulted in inadequate care.</p>	R 008			



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BUREAU OF FACILITY STANDARDS  
P.O. Box 83720  
Boise, ID 83720-0036  
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING  
Non-Core Issues  
Punch List

Facility Name <i>The Cottages of Mountain Home</i>	Physical Address <i>735 S. 5<sup>th</sup> West St</i>	Phone Number <i>208-580-1121</i>
Administrator <i>Karen Kleffner</i>	City <i>Mountain Home</i>	ZIP Code <i>83647</i>
Survey Team Leader <i>Patrick Henderson</i>	Survey Type <i>STANDARD</i>	Survey Date <i>1/2/07</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1.	153.06	The facility did not have a policy on how to intervene to assure Residents safety in unsafe physical situations (ie: low blood pressures).	2/8/08	
2	300.01	The Licensed Professional Nurse did not visit the facility when there was a change in the Residents condition for Residents # 1 and # 4.	2/8/08	
3	305.01	The facilities nurse did not conduct a nursing assessment of each Residents response to medication or prescribed therapies for Residents # 1, 2	2/08/08	
4.	305.04	The facilities nurse failed to make recommendations to the Administrator with regards to any health needs requiring follow-up or changes needed to the USA for Residents # 1, 2, 3 and 4.	2/8/08	
5	305.06	The facilities nurse did not conduct an initial nursing assessment to assure Resident # 2 was safely self-administering insulin nor review Residents ability every 90 days.	2/8/08	

Response Required Date

Signature of Facility Representative

Date Signed

*2/2/07*

*1/5/08*



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ASSISTED LIVING  
Non-Core Issues  
Punch List

Facility Name <i>The Cottages of Mountain Home</i>	Physical Address <i>735 S. 5<sup>th</sup> West St</i>	Phone Number <i>208-580-1121</i>
Administrator <i>Karen Kleffner</i>	City <i>Mountain Home</i>	ZIP Code <i>83647</i>
Survey Team Leader <i>Patrick Hendrickson</i>	Survey Type <i>STANDARD</i>	Survey Date <i>1/2/07</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
6	305.07	The facility nurse did not notify Residents #2's authorized provider or physician of any identified concerns of prescribed medications. (ie: BP meds)	2/8/07	
7	305.08	The facility nurse did not document and recommend any hearthome related educational needs for staff. (ie: BP parameters)	2/8/07	
8	310.01	Residents were assisted with medications using a bulk distribution system.	2/8/07	
9	320.08	The facility did not review residents' NSAs when there was a change of condition or at least every 12 months for Residents #1, #2 and #4.	2/8/07	
10	350	The facility's administrator did not assure that the facility's policies and procedures were implemented for all incidents for Resident #3's fall on 12/11/06.	2/8/07	
11	405.03	Medical Gases (O <sub>2</sub> ) were not restrained.	COS	
12	250.10	The facility's hot water temperature was 139.2.	2/8/07	
Response Required Date <i>2/2/07</i>		Signature of Facility Representative <i>[Signature]</i>	Date Signed <i>1/5/07</i>	





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ASSISTED LIVING  
Non-Core Issues  
Punch List

Facility Name <i>The Cottages of Mountain Home</i>	Physical Address <i>735 S. 5<sup>th</sup> West St</i>	Phone Number <i>208-580-1121</i>
Administrator <i>Karen Kleffner</i>	City <i>Mountain Home</i>	ZIP Code <i>83647</i>
Survey Team Leader <i>Patrick Henderson</i>	Survey Type <i>Standard</i>	Survey Date <i>1/2/07</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
13	450	The facility did not meet the standards of the Idaho long term care.	COS	
14	650.02	The Residents UAT's did not include: Medical diagnoses, background information, behavior patterns, cognitive function, and medical health problems.	2/8/07	
15	650.04	The facility did not review residents UAT's when there was a change of condition or at least every 12 months for Residents #1, #2 and #4.	2/8/07	
16	711.01	The facility did not have Behavioral Management records for Residents #1 and #4.	2/8/7	
17	711.04	Staff did not document the Residents refusal of care, consequences of the refusal and notification of the residents physician for Resident #2.	2/8/07	
18	711.08.E	Care notes did not include notification of the facility's nurse for changes in residents physical or mental conditions.	2/8/07	
19	711.11	Medused medications were not documented for Resident #2	2/8/7	

Response Required Date

Signature of Facility Representative

Date Signed

*2/2/07*

*1/5/07*



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## ASSISTED LIVING

### Non-Core Issues

### Punch List

Facility Name <i>The Cottages of Mountain Home</i>	Physical Address <i>735 S. 5<sup>th</sup> West St</i>	Phone Number <i>803-580-1121</i>
Administrator <i>Karen Kleffner</i>	City <i>Mountain Home</i>	ZIP Code <i>83647</i>
Survey Team Leader <i>Patrick Henderson</i>	Survey Type <i>Standard</i>	Survey Date <i>1/2/07</i>

## NON-CORE ISSUES

[illegible]

Response Required Date

Signature of Facility Representative

Date Signed \_\_\_\_\_

2/2/07

\_\_\_\_\_

15/07